Patient Health History New Patient

Today's Date ___________________

First Name __________________ **Middle Name** __________________ **Last Name** ________________________

Address 1 ____

City ____ **State** _____________ **Zip Code** ______________________

Primary Phone ______________________________ **Work Phone** ____________________________________

Mobile Phone ____

Home email _________________________________ **Work Email** ____________________________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Work Phone ❑ Mobile Phone

Date of Birth ____________________ **Gender** *(check one)* ❑ Male ❑ Female

Females only: **Pregnant?** ❑ Yes ❑ No **Due Date** _______________________

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** ____________________________________

Employment Status *(circle one) Employed / FT Student / PT Student / Other / Retired / Self Employed*

Employer's Name / Occupation ____

Employer's Address / Phone ____

Spouse's Name / Phone ____

Guardian's Name (if under 18) / Phone ____

Emergency Contact's Name / Phone ____

For Insurance Purposes: Policyholder's Name / DOB ____

Present Family Physician ____

Most Recent Chiropractor Seen _________________________________ **Date of Last Visit** _________________

How did you hear about us *(circle one) Newspaper / Website / Phone Book / Other Healthcare Provider /*

Other _____________________ */ Patient* ________________________

Race *(check one)*

❑ White ❑ Black/African American ❑ American Indian/Alaskan Native

❑ Asian ❑ Native Hawaiian or other Pacific Island ❑Other__________________

❑ I choose not to specify

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language: ____________________________

Verification Question : What is your mother's maiden name?

Verification Answer : __________________________________

Continued …

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker
(for patients 13 years and older)

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑ **Pharmacy Name / City** ____

1) ____ **5)** ____

2) ____ **6)** ____

3) ____ **7)** ____

4) ____ **8)** ____

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ____ **3)** ____

2) ____ **4)** ____

Briefly list your main health problems: ____

____

Do you have a history of strokes? ❑ Yes ❑ No **Aneurysms?** ❑ Yes ❑ No

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _______________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Patient's Signature ____

Parent/Guardian Signature ____

To be performed by clinic staff:

Height: ___________ **inches** **Weight:** ___________ **pounds** **BP:** ______/______ **Pulse:** __________